Testimony

presented to

The Senate Committee on Indian Affairs

regarding

S. 556 - A bill to reauthorize the Indian Health Care Improvement Act

by

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Mr. Chairmen and distinguished members of this committee. My name is Everett Rhoades. Since my retirement as Director of the IHS in 1993, I have had the privilege of serving on the Board of Directors of the Oklahoma City project. I am accompanied by Mr. Rufus Cox, President; Mr. Terry Hunter, Chief Executive Officer; and Ms. Robyn Sunday, Chief Operating Officer of our organization. We are pleased to offer testimony relating to Title V of the Indian Health Care Improvement Act. As one of two special urban health demonstration projects established by the Congress in 1987, we believe that our experiences during the past several years are worthy of consideration by the Congress.

The Central Oklahoma American Indian Health Council, Inc., also known as the Oklahoma City Indian Clinic (OKCIC), is a 100% Indian-controlled not-for-profit corporation established in 1974 to serve the health care needs of American Indians in Oklahoma City. We appear today primarily to call attention of the committee to the circumstances relating to the fact that we, along with the Tulsa program, have certain important issues relating to our status as Demonstration Projects.

Urban Indian Health and Title V of the Indian Health Care Improvement Act

As a result of the Bureau of Indian Affairs Relocation Program during the 1950s and 1960s and other employment opportunities, large numbers of American Indian and Alaska Natives (AI/AN) moved to metropolitan locations throughout the United States. The American Indian Policy Review Commission, established by the Congress, in 1976 estimated that as many as 160,000 American Indians and Alaska Natives were relocated to urban centers during the BIA Relocation Program.[i] While many Indian families did well in the cities, thousands found themselves without basic services, especially health care. Further, although complete data were not available, widespread experience indicated that the general health of most urban Indians in fact was less than for those remaining in traditional Indian communities.

In order to address the serious and growing problem of lack of access to basic health care, a number of the larger cities, such as Los Angeles, Oklahoma City, Tulsa, Seattle, Minneapolis and San Francisco established volunteer Indian centers and free health clinics. However, these were small local efforts and until 1976, urban Indian populations remained largely neglected by the federal health system. Even today, they occupy a relatively minor position in the IHS health care programs. For example, while the IHS provides funding to 34 urban Indian health centers and provides alcohol treatment resources to urban Indian alcohol programs, the FY 2003 appropriation for urban health programs was $31 million. This supports 34 urban programs. The Urban Health Program represents less than 1% of the total IHS annual budget.

The Congress moved to address the growing problem of urban Indian health care and the 1976 Indian Health Care Improvement Act (IHCIA) provided authority for urban health programs through its Title V. This provision authorized the IHS to provide funding to health programs serving urban Indian populations. The enactment of Title V was a pivotal turning point for urban Indian health programs across the nation.

The Oklahoma City Indian Clinic (OKCIC)

As in the case of all the early urban health programs, in the late 1960s a small group of individuals in Oklahoma City established a program designed to provide health services to the large and growing Indian population. Enterprising individuals sought funding from a variety of sources, and through generous donations of professional services and equipment, began to provide the only health care services available for many Oklahoma City Indians. The financial resources available were very small grants from a number of government and nongovernment sources, but not sufficient to sustain any kind of ongoing program. The Oklahoma City Indian Clinic (OKCIC) began as a clinic staffed by volunteer physicians and nurses operating with donated medical supplies and equipment in the standard abandoned store front. While the IHS was not specifically provided funds to establish health care programs in metropolitan locations, it provided minimal amounts of funding, basically for needs assessments in order to estimate the extent of lack of health care in urban locations. Following enactment of P.L. 94-437, modest IHS funding began to become available for urban Indians, including the OKCIC.

Today, the OKCIC serves an eligible population of 45,000 Indians. The Clinic's active patient count is 14,437. The Clinic applies the same criteria used by the Indian Health Services (IHS) for patient eligibility.

The annual cost per patient cared for by OKCIC is far below the national average, at $495 cost per patient. This compares to the IHS average of $1,920, and Medicare's $5,600, and Medicaid's $3,859. Within the constraints of this dramatic under funding, the OKCIC provides state of the art ambulatory care with a highly trained and dedicated staff. The OKCIC was founded as a nonprofit corporation in 1974. In 1977, it received $201,000 from the IHS. The IHS allocation to the OKCIC in FY 2003 is $4,619,664.

Oklahoma Demonstration Projects

Both the Oklahoma City and Tulsa projects originally contracted with the Indian Health Service under Title V of the Indian Health Care Improvement Act as Buy Indian Act contractors. In the years following enactment of the IHCIA, Urban Health Programs remained seriously underfunded and were vulnerable to efforts to reduce their funding even further. In 1987, the Oklahoma Congressional delegation advocated that the two urban programs in Oklahoma become demonstration projects, which would remove their funding from the vulnerable Urban Health account and provide funding through the IHS Hospitals and Clinics account. The Oklahoma City and Tulsa urban Indian clinics were designated Demonstration Projects by the U.S. Congress through a line-item appropriation in the Fiscal Year 1987 Interior Appropriations Act. Specifically, Congress provided:

> *within the amount provided, the Committee has transferred $1,000,000 from the Urban Health Program for a demonstration project to integrate the Oklahoma City and Tulsa projects with the Direct Care Program. (Senate Report No. 99-397)*[ii]

The Congress clearly intended that these programs be regarded as integral units of IHS programs with the clear expectation that they receive a larger *and more equitable allocation* of IHS resources. However, while some increases were realized, they were far below what should have been provided based upon the number of individuals served by each program.

The continuing inequity in resources resulted in further congressional attention. In Fiscal Year 1994, after the IHS provided a comparison of "level need funded" (LNF) to congressional appropriations committee staff, it was clear the two demonstration projects were funded far less, on a per patient basis, than other Service Units in the Oklahoma Area. Following the funding increases specifically provided by the Congress in Fiscal Year 1994, each project replaced their dilapidated facilities, moved into newly constructed facilities, and tremendously expanded services to needy Indians. The special nature of the urban programs is reflected in the now commonly utilized acronym: ITU, which stands for Indian Health Service, Tribal, and Urban programs.

A Hybrid Model

While the Congress clearly intended that these programs be considered the same as IHS Service Units, the IHS contracts with each under authority of Title V. In so doing, the Demonstration Projects continue to meet the definitions described for Title V programs. Both provide services in an "urban center" and each is governed by "an urban Indian controlled board of directors." Thus, the Demonstration Projects are clearly hybrid models, with aspects of both urban and Service Unit programs. For example, the IHS Office of General Counsel's opinion issued on October 4, 1989, said the projects *"…are no longer a part of the Title V urban program but rather are now part of the regular IHS program."* Yet, in other instances the IHS has stated that these programs "as urban programs" could not be fully integrated or funded, as it did in its report to Congress in March 1993 regarding funding for facility construction. In addition, the question of potential contracting of the Demonstration Projects by tribes themselves was addressed.

The question of tribal contracting of either or both of the Demonstration Projects was addressed by the Office of General Counsel on October 22, 1992. In this instance, General Counsel did not address the Title V definitions but relied solely on the new provisions of the 1992 amendments, which *explicitly prohibited such tribal contracting*.

The 1993 Report to Congress stated the Projects were receiving some funding increases for new programs, such as mental health, substance abuse, AIDS/HIV prevention and public health nursing, but far less than the resources that should have been made available based upon their respective patient populations. The report clearly stated that funding for facility replacement was out of the question because of their status as urban programs. Responding to congressional concern that the demonstration projects continued to occupy dilapidated facilities and were not fairly considered for the IHS facilities replacement priority, the IHS responded:

" . . . the IHS needs to decide if it should construct Federal health care facilities to house health service delivery programs operated by non-tribal contractors …An IHS determination to place these types of facilities on its health facilities construction priority lists would constitute a major change in health facilities construction policy."[iii]

The projects are not operated exactly like an IHS facility, tribal program or urban program. They are unique. Regardless of this, the programs are integral components of the Oklahoma Area service delivery system. Each maintains its Title V status, as an "urban Indian organization" and is governed by an urban Indian board of directors. Contracts are signed with the IHS under the authority of Title V of the IHCIA and under the authority of the Buy Indian Act. Yet, according to Section 512, the programs are clearly intended to be funded on the same basis as existing IHS Service Units.

Urban Governed Board

Section 4 of the IHCIA provides definitions, which are referenced in Title V for eligible urban Indian organizations and patients. Those include the following:

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection () (1) through (4) of this section.

(g) "Urban center" means any community, which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503 (a)[iv].

In numerous examples, such as board composition, patient billing, and certain resource allocations (diabetes initiative), the programs have been treated like urban programs. In other examples, such as patient eligibility, Medicaid and Medicare billing, categorical funding and mandatory increases, the programs are treated like Service Units. The contract between the IHS and the demonstration projects have not changed since their demonstration status. Each contract still references as its authority Title V of the IHCIA.

Congress Funded New Facilities in FY 94

In the Fiscal Year 1994 Interior Appropriations Act, Congress provided funds for facility replacement. The IHS provided the House and Senate Appropriation Subcommittees with an analysis of local Service Unit needs *including the two demonstration sites* based upon an IHS formula called "Level of Need Funded" (LNF). The comparison was shocking and confirmed the claims of the demonstration sites that they were not being funded proportionately. The following table clearly illustrates these disparities:

Unit/Location		LNF
Claremore Service Unit		75.2%
Tulsa Demonstration Project		59.5%
Shawnee Service Unit	63.5%	
Oklahoma City Demo Project	39.1%	[v]

Congress, based upon these data, provided explicit instructions to IHS as follows:

> *"It is the Committee's understanding the amount reflected for the Shawnee's unit will be allocated entirely to the Oklahoma City clinic and the Claremore funds are to be allocated to the Tulsa clinic. Within the increase provided, funds may be used for a new lease for expanded space. As discussed above the increased costs of this space must be accommodated within the amounts provided." (Senate Report 103-114)*[vi]

Both Demonstration Projects promptly moved to develop new and expanded replacement facilities as a result of the actions of Congress.

Why the Oklahoma Area is Unique

The entire state of Oklahoma is a "Contract Health Service Delivery Area" (CHSDA). The patients in Oklahoma City and Tulsa are located within the Area-wide CHSDA and are therefore IHS eligible patients, counted by the IHS as a significant percentage of the total user population. When Congress provides funding increases to the IHS based upon LNF, it does so in part by counting the patients in Oklahoma City and Tulsa.

In the preamble to 42 CFR Part 36 Subpart C, the IHS explains that a compelling reason to designate the entire state a CHSDA is the existence of the urban populations in Tulsa and Oklahoma City:

> *"This change (making the state CHSDA) is due to the high incidence of utilization of and dependence on IHS facilities by eligible Indian residents of Tulsa and Oklahoma City. Under the NPRM, if eligible residents of the two cities presented themselves to an IHS facility, they would be eligible for care but if the IHS facility for any reason could not provide the needed direct care, the individuals would not be eligible for contract health services. This makes neither administrative nor programmatic sense due to the reliance the affected population places on IHS for health care services."*(43 Federal Register 34650, August 4, 1978)

Because these Oklahoma City and Tulsa populations are included within the Oklahoma Area-wide CHSDA, it is entirely appropriate for the Congress to maintain the Demonstration Projects to serve them.

Further, the allocation of resources for these two programs should be *on the same basis as for other Oklahoma IHS and tribal programs.*

The Oklahoma Demonstration Project is a Resounding Success

Attesting to the success of the Tulsa and Oklahoma City projects has been the provision of state of the art Indian health care programs in modern, clean, well lighted and dignified facilities. With expansion of highly trained administrative and clinical personnel, a wide array of preventive and therapeutic services are provided to large numbers of urban Indian patients, most of whom would otherwise be without health care. Both programs are widely recognized as leaders in the provision of health services for American Indians. They have proved the wisdom of the Congress in establishing the Demonstration Projects.

Two Continuing Issues

Two issues require continued Congressional attention: 1) The equitable distribution of funding increases received by the IHS and the Oklahoma Area and 2) continued protection from tribal attempts to contract for the urban programs or to withdraw their shares from the programs.

Oklahoma City and Tulsa Patients Denied Funds

Despite the explicit instruction in Section 512, the two programs are not funded on the same basis as Service Units of the IHS. While the Oklahoma City and Tulsa populations are included in Oklahoma Area requests for additional resources, the two Demonstration Projects do not share equitably in increased resources received by the Area. Instead, Area funds are divided through tribal consultation among the Oklahoma tribes, with little or no regard for the population numbers of the Demonstration Projects *used to generate these resources*. Each of the two programs has had to continually fight for its rightful proportion of any increases in IHS funding. Only the intervention of Congress in FY 94 resulted in a more equitable allocation of resources, based upon the numbers of individuals in each program. A comparison of user population and funding allocations for the former Shawnee Service Unit is presented in Figure 1, whic illustrates the disproportionate misallocation of resources.

Another example of penalties experienced by the two Deomonstration Projects in the allocation of resources is the distribution of the special diabetes monies. As illustrated in Figure 2, based upon populations served, the awards to OKCIC since FY 98 are far below the amounts that should have been received. For example, in FY 00, the IHS formula indicated that OKCIC should have received $637,169. However, it received only $130,879.

The Area Office has pointed to the existing Section 512 language, insisting that had Congress identified the two Demonstration Projects as "operating units" instead of "service units", they would share in increases. We believe this is an artificial distinction, but in order to resolve the issue, we request that the Congress explicitly designate the Demonstration Projects as operating units. The previous intention of the Congress that these programs be funded on the same basis as all other Service Units, or as the case may be, Operating Units, must be reiterated and made permanent.

Tribal Take-Over of Urban Programs is a Wrong Precedent

Urban programs have always strongly supported tribal sovereignty and continue to do so. The Oklahoma Demonstration Projects are not about tribal sovereignty. The Oklahoma City project provides services to patients belonging to more than 200 tribes located both within and outside Oklahoma. Further, the Oklahoma City clinic is not located within any tribal jurisdiction. Recently, certain tribes have proposed contracting under P.L. 93-638 to contract for the two Demonstration Projects or to withdraw tribal shares from each. Section 512 explicitly prohibits this from happening, and *this provision must be protected and made permanent*. The two Demonstration Projects fill an important void in access to health services for more than 33,000 urban Indians in the Oklahoma CHSDA. Tribal assumption or dismantling of the two demonstration projects would cause disastrous and irreparable harm for the 33,000 urban Indian patients. The tribes would not serve the urban populations. There has been no record or demonstration that tribes in Oklahoma are interested in the health care of Oklahoma City and Tulsa Indians. On the contrary, the

real basis for the arguments to take over these programs is a desire to shift funding to tribal clinics and facilities.

The numerous tribal affiliations represented among patients served by the OKCIC indicate that no single tribe could assume the entire operation of this entity. Rather, what is proposed is the incremental disintegration of the existing program to the point where it becomes ineffective or ceases to exist. Given the tremendous workload each demonstration project carries within the Area, elimination of one or both projects would create irreparable calamity within the total Indian health system in Oklahoma.

If Congress allows tribes to "take over" and/or "take away" the limited funds available to urban Indian health clinics under the authority of the Indian Self-Determination Act, it could start a trend nationally which would threaten one of the most inadequately funded components of the Indian health system, urban health. The other 32 urban programs operate on far less funding than do tribal or IHS facilities. Allowing tribal contracting of Oklahoma City and Tulsa would threaten to eliminate or erode the basic health services available to these populations.

The two demonstration projects have become integral components within the I/T/U delivery system of the Oklahoma Area. There is no excess capacity in other tribal or IHS facilities to absorb the 33,000 urban users if these programs were to be discontinued or eliminated. It is one thing to support the Self-Determination of tribes to take-over and operate federal services that are designed to serve those *tribal populations*. It is entirely inconsistent with P.L. 93-638 to allow tribes to reach beyond their service boundaries to siphon away resources of other effective programs in order to bolster tribal health budgets. Further, the Congress in 1992 expressly indicated that these programs were not to be subject to tribal contracting. We simply request that this provision be made permanent.

Conclusion

Section 512 of the Indian Health Care Improvement Act must provide permanent authority for the Oklahoma Demonstration Projects and protect them from tribal contracting under P.L. 93-638. The Congress has already made a substantial investment in the two Oklahoma Demonstration Projects, including the financing of newly constructed facilities. The success of the programs attest to the wisdom of the Congress in establishing these outstanding programs. It is absolutely critical that the Congress continue to protect the IHS eligible patients in Oklahoma City and Tulsa. Significant and irreparable harm will come to these IHS eligible patients if Section 512 of the IHCIA is not continued or made permanent.

There are no IHS or tribal facilities that could absorb the tens of thousands of patients from Oklahoma City or Tulsa if these programs were eliminated. Further, there are no other health care programs in the metropolitan area that could provide care to these patients. Tribal efforts to take over these Demonstration Programs are an effort to increase much needed funding for tribal programs. We strongly urge substantial increases for both tribal and urban health programs so that these conflicts will be unnecessary.

In addtion to the above concerns, the present system of resource allocations to the Demonstration Projects

is seriously inequitable and requires correction.

We urge support for S. 556 section 512 as described below.

SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

`(a) TULSA AND OKLAHOMA CITY CLINICS- Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs ~~within the Service's direct care program~~ and ~~continue to~~ be treated as service units *or operating units* in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act. (Italics: proposed change to S.556)

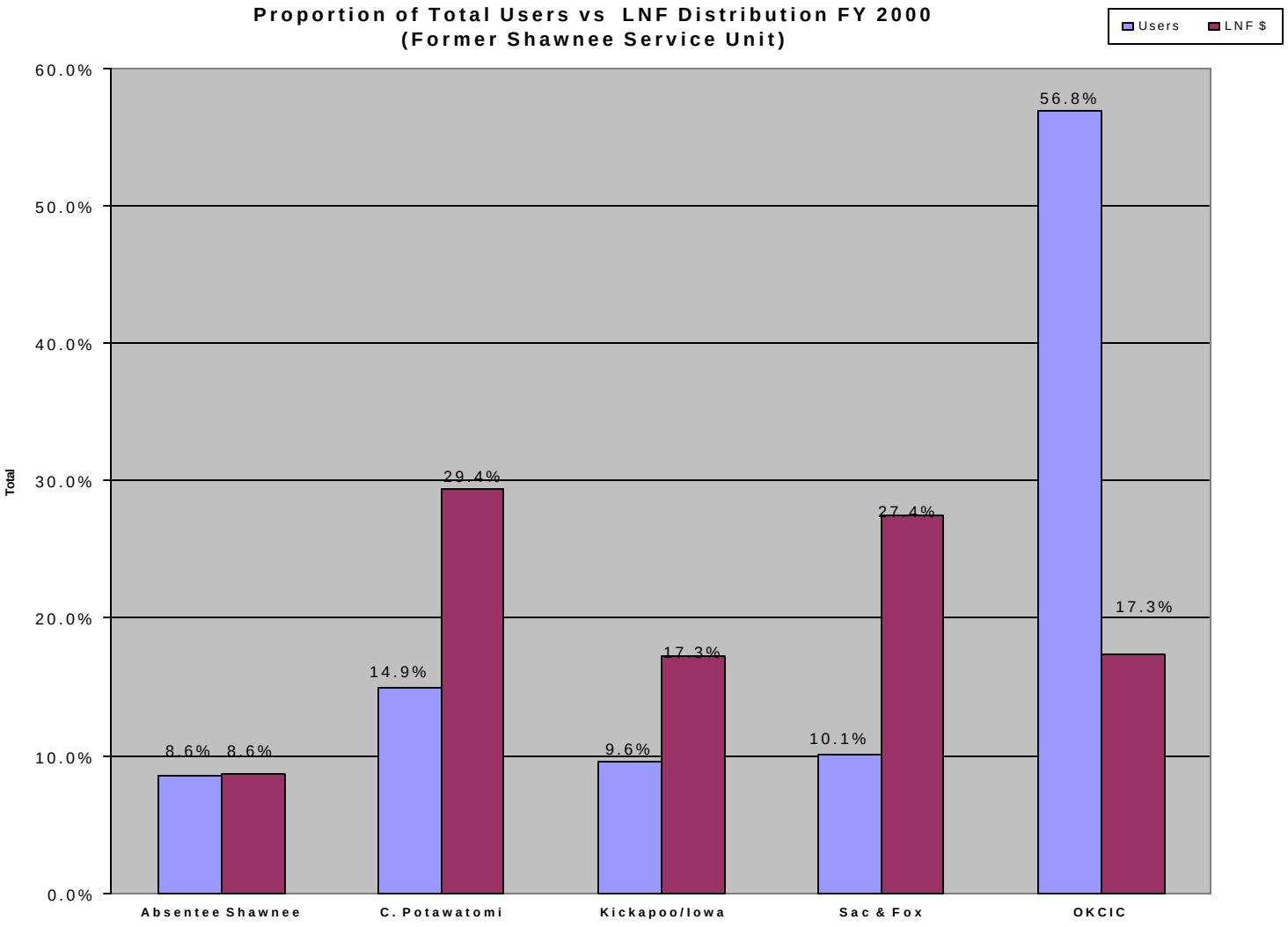
Proportion of Total Users vs LNF Distribution FY 2000
(Former Shawnee Service Unit)
Users
LNF $
Total
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
8.6%
8.6%
14.9%
29.4%
9.6%
17.3%
10.1%
27.4%
56.8%
17.3%
Absentee Shawnee
C. Potawatomi
Kickapoo/Iowa
Sac & Fox
OKCIC

figure 1.

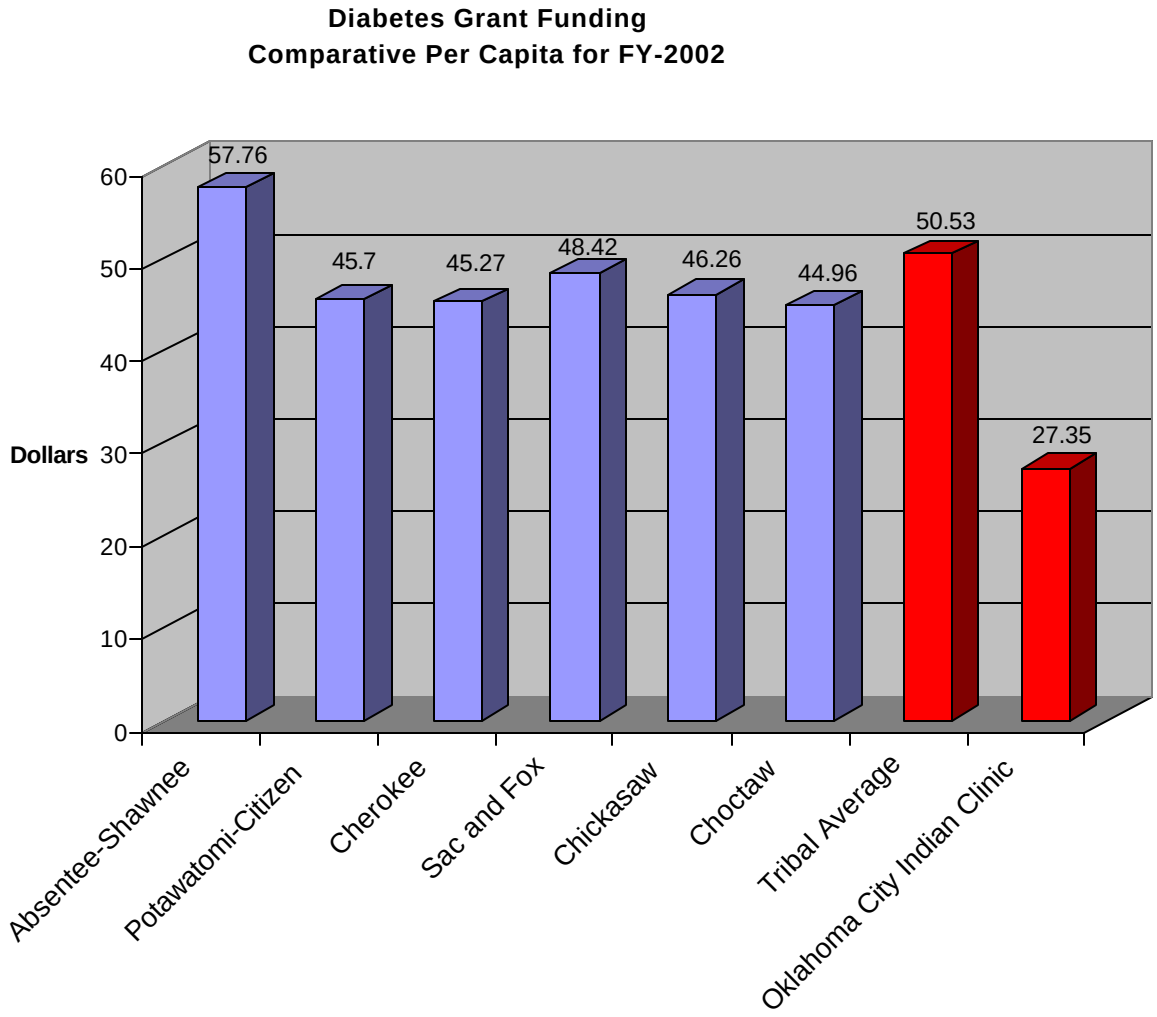
Diabetes Grant Funding
Comparative Per Capita for FY-2002
Dollars
60
50
40
30
20
10
0
57.76
45.7
45.27
48.42
46.26
44.96
50.53
27.35
Absentee-Shawnee
Potawatomi-Citizen
Cherokee
Sac and Fox
Chickasaw
Choctaw
Tribal Average
Oklahoma City Indian Clinic

figure 2.

References

i U.S. Congress, American Indian Policy Review Commission, Task Force Report on Off-Reservation Indians, 1977

ii United States Senate Report No. 99-397, to accompany Fiscal Year 1987 Interior Appropriations Act

iii Lincoln, Michel E., Acting Director, U.S. Indian Health Service Department of Health and Human Services, “Report to Congress on the Oklahoma City and Tulsa Clinics in Response to Senate Report No. 102-345” March, 1993

ivIndian Health Care Improvement Act (P.L.94-437), as amended through October 19, 1996 “Annotated Codification” prepared by the Indian Health Service, Legislative Affairs Staff, Office of the Director, April 1998.

v Kauffman, JoAnn, for the Indian Health Service, “Final Report: A comparative evaluation and assessment of the IHS Oklahoma City and Tulsa Indian health delivery sites”, 1994.

vi United States Senate, Report #103-114, to accompany the Fiscal Year 1994 Interior Appropriations Act